WELCOME TO ARTHUR STREET DENTAL
CHILD MEDICAL HISTORY

Address:……

Suburb:……State:……Postcode: ……

Email:…….....

1.Parents/ Legal Guardian name/s and contact numbers

……

2.Parents/Legal Guardian name/s and contact numbers

……

Child #1

Title: Miss, Master

First Name/s:…… Preferred Name: ……..

Surname……

Date of Birth ……/……/……

Health Insurance Provider (if any): _____ Membership Number: _____

Line Number: _____

Medicare Card Number …….. Line Number next to name:……..

Child #2

Title: Miss, Master

First Name/s:…….. Preferred Name: ……..

Surname……

Date of Birth ……/……/……

Health Insurance Provider (if any): _____ Membership Number: _____

Line Number: _____

WELCOME TO ARTHUR STREET DENTAL
CHILD MEDICAL HISTORY

Medicare Card Number ……. Line Number next to name:……

Have they ever had or are they suffering from any serious illness?……..

……

Please circle if they have any of the following:

Heart problems	**Excessive Bleeding**	**Rheumatic Fever**
Osteoporosis	**Diabetes**	**Asthma**
Hepatitis	**HIV/ AIDS**	**Reflux**

Blood pressure: High/ Low/ Normal

Are they taking any medications (drugs, pills etc) at present (please specify)?

……

Are they allergic to any medications (Penicillin, Codeine, Sulphur, Latex etc)?

……

Do the child/children have any of the following habits? Please circle if applicable & add name:

Grinding teeth problems	**Mouth Breathing**	**Chewing/Eating**
Prolonged bottle/pacifier	**Speech problems**	**Finger/thumb sucking**

Do they feel nervous about having dental treatment? If so, what is their biggest concern?

.....

Please note any further concerns:
……

……

When was their last visit to the dentist/ How long since their last dental x-rays?

……

Independent Child Appointments

WELCOME TO ARTHUR STREET DENTAL
CHILD MEDICAL HISTORY

Arthur Street Dental is trialling children attending treatment appointments without a parent/guardian in the room. This approach often improves confidence, communication, focus, and appointment efficiency, and is commonly used in paediatric dentistry. Our team is trained in child-friendly care, and anxious or very young children are assessed on a case-by-case basis. Parents will be informed before treatment, called in if needed, and provided with a full summary after the appointment.

Photo/Video Consent

☐ I consent to Arthur Street Dental taking clinical photographs and/or videos of my child for dental records and treatment planning.

☐ I consent to de-identified photographs/videos being used for education or marketing purposes.

☐ I do not consent.

Consent for Treatment

1.Upon diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

2. I accept responsibility for payment of services provided for my child/children. Payment is required on the day of treatment unless prior arrangements have been made.

2. I accept responsibility for payment of services provided for my child/children. Payment is required on the day of treatment unless prior arrangements have been made.

PLEASE PROVIDE AT LEAST 48 BUSINESS HOURS' NOTICE IF YOU NEED TO RESCHEDULE OR CANCEL. LATE CANCELLATIONS OR MISSED APPOINTMENTS MAY INCUR A $100 DEPOSIT TO SECURE FUTURE BOOKINGS.

Signature:……**Date**:……../……../……

Thank you for your cooperation

All information supplied is for us only (regarding dental treatment) and this is a confidential questionnaire.